New Services Subcommittee Meeting Minutes

Meeting Minutes: 12/03/2015

Attendees: Kim Malsam-Rysdon; Lynne Valenti; Brenda Tidball-Zeltinger; Jerilyn Church; John Mengenhausen; Monica Huber; Michael Coyle; Edmund Johnson, Jr; Sonia Weston; Dr. Tad Jacobs; Capt. John Schuchardt; Bernie Long

Welcome and Introductions

Don Novo with HMA welcomed the group to the meeting. The recommendations from all the subcommittees will need to go to the Health Care Services Coalition by December 16 meeting. This meeting will be the last New Services Subcommittee meeting.

Review of November 18 Meeting Minutes

Don reminded Subcommittee members to review the November 18th meeting minutes @ http://boardsandcommissions.sd.gov/Template.aspx?id=145 and to send any comments or revisions to Kelsey Smith @ Kelsey.Smith@state.sd.us

At the previous meeting, there was a brief overview of the Community Health Worker (CHW) programs in several other states, including Oregon, New Mexico, South Carolina, Texas, and Washington. The subcommittee also discussed some of the Community Health Representative (CHR) program within IHS. The group discussed the need to ensure standards and training and develop appropriate reimbursement structures for CHWs/CHRs in South Dakota. This approach included ensuring Tribal health programs bill for non-emergency transportation services through existing funding mechanisms.

There also was a discussion about how the Medicaid pharmacy benefit is structured and opportunities to incorporate Medication Therapy Management as part of Health Homes.

Tribal CHR program survey results

Jerilyn Church noted that there were only four completed surveys to date, but they will continue to outreach for more information. Jerilyn Church noted that they would do this survey area-wide and continue to pursue information from the Tribes that has not yet responded.

The CHRs that responded noted that they have a lot of long-term staff, but it is hard to recruit new staff to be CHRs due to lower wages and challenging work. All the CHRs are certified and they provide a wide variety of services including in-home health care, transportation, patient advocacy, health education, medication assistance; and other services such as help with case management, eligibility, and enrollment in programs, and referrals and assistance accessing other services. Many CHRs participate in Talking Circles and grief support, as well.

~~The CHRs serve people at various income levels and~~ there is a wide variety of programs that use the CHRs including specialty clinics and programs that support individuals with disabilities. Transportation takes up a great deal of their time and some are billing Medicaid, some are not, for a variety of reasons. Sustainability is an issue, and some administrators noted they are not usually able to maximize the use

of their CHRs because they operate in crisis mode most of the time and are chronically understaffed and underfunded.

Priority of Services (as noted by CHRs):

1. Prevention and health education
2. Outreach and education
3. Patient and community advocate
4. Transportation

There was a question about whether the CHRs deliver services as a part of a team. They are a very tight-knit group and have been working together a long time. Many are getting close to retirement and there are concerns regarding recruitment of new workforce. The care is directed from the clinics. Services are fairly standardized but they also have flexibility to meet individual patient needs. They do have a lot of training, and they are open to learning more. Many have certifications in multiple disciplines.

Kim Malsam-Rysdon noted that the State would need to develop consistency and formalize the program for it to work within the Medicaid program, as well as for the Tribes, IHS and other service providers. It will be important to expand the model to support more than just crises response and transportation and to allow the CHWs/CHRs to provide more types care and services.

Develop working definition of CHR services in South Dakota

The goal is to identify CHR services, the target population, and staff qualifications to propose s new services that are reimbursable by Medicaid. The group discussed the key areas of focus for CHWs/CHRs.

<u>Service Definition - Services provided face-to-face to include:</u>

- Health promotion and helping people stay well
- Arranging for transportation (as opposed to providing the transportation; provision of transportation can and should be billed to Medicaid today)
- Disease specific education (targeting specific disease states that are most prevalent in each community)
- Direct care provision for specific things such as vital signs, medication monitoring, wound care, dietary counseling
- Personal care/homemaker services, environmental assessments
- Navigation of the health system and getting access to the right providers

To be eligible for Medicaid reimbursement, services must be physician directed/ordered by physician, physician assistant or other primary care provider.

<u>Target Populations:</u>

- Individuals served through Medicaid Health Homes should get these services through that service and not be eligible for CHR services outside the Health Home
- Individuals should be referred by primary care provider and CHR will assist in implementing certain provisions of the care plan

- Individuals needing assistance with transition to community after hospitalization or services to avoid admission
- Pregnant women who need assistance to access prenatal care
- Individuals with substance abuse or mental health needs who need assistance after inpatient treatment

CHR Qualifications

- Need to be members of the community
- Extension of clinical coordinators and part of the care coordination team
- Leverage existing certification such as CNA or the Indian Health Services CHR training curriculum. CMA work is typically found more in a clinic setting but should be recognized as meeting requirements for certain types of care provided especially if doing any direct care; a tiered approach starting with a core set of services and opportunities for expanding to other certifications or training.
- There is interest from an AHEC in South Dakota to develop CHW/CHR training programs and curriculums. It would be helpful to work with the AHEC and the Department of Health, and IHS to build resources across the state. The Great Plains Chairman's Tribal Health Board is also looking at ways to support additional opportunities for training CHRs. The GPCTHB also just received a grant to help individuals access training for certain jobs, including CNA certification.
- It is important to hire CHWs/CHRs with the competencies to provide care and build trust with patients.

The group also discussed the value in a tiered qualification model based on the type of service. The group concurred it would be helpful to develop a matrix or grid of levels of CHW/CHR staff training requirements related to specific roles and responsibilities. CHW/CHR work can be similar to the personal care, or homemaker model, but would be for different populations. To the degree individuals need homemaker or personal care those services should be being billed to Medicaid today. This new service should be distinctly separate as the target population would be different and it will be important to clearly identify the services and populations. There is a strong need for both types of services in South Dakota. For example, there is a program in Pine Ridge called Circle of Life that is a Medicaid-contracted program. But they are very limited in how much time they can bill for based on their capacity and current contract with Medicaid.

The group reviewed the service definition, requirements for referral, training and qualifications, and concurred that this represents the subcommittee recommendation for CHR services.

How to Engage CHWs/CHRs

- Making CHWs/CHRs a part of the clinical care team and care plan – needs to be provider-driven (e.g., referred by and physician, PA, NP).
- Clear roles for public health nurses, CHRs, home health providers. A tiered approach to allow CHRs all to start at the same level and move into a higher level if they are able/desire. Allow flexibility to tailor CHR programs and teams to the specific needs of each community.
- The ability for CHRs to conduct group visits, particularly for patient education.
- CHRs supporting behavioral health, especially for ongoing management and support. CHRs can serve as peer support specialists; and can support medication management to ensure people

are taking their medications appropriately, educating family members, etc. The PHQ9 behavioral health screening could be administered by CHRs.

Next steps: A smaller group will work through the next level of detail to develop program specifics for the purposes of identifying necessary changes for the addition of this service to the Medicaid state plan. The group will assess the fiscal impact of this recommendation and identify options for reimbursement and coverage.

Recommendation for Medication Therapy Management as part of Health Homes

The subcommittee had discussed this as a potential new service. John Schuchardt confirmed from the last meeting discussion that he verified the majority of individuals that could benefit from MTM are served in or eligible for Health Homes. Given that, the subcommittee does not have specific recommendation to add MTM but will note that this service should be leveraged through Health Homes. Additionally, more provider systems are incorporating pharmacists into their care teams and there also are opportunities to increase care and medication support through telehealth.

Next Steps:

- A written summary of the subcommittee recommendation for CHR services will be developed and provided to the larger coalition for consideration.
- There will be a smaller group assembled to work on developing the details of an actual CHW/CHR program for the State to submit to CMS through a State Plan Amendment.

REMINDER - All the materials from the Coalition and Subcommittees are located on *boardsandcommissions.sd.gov*